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Report to the Chairman, Subcommittee
on Military Forces and Personnel,
Committee on Armed Services,
House of Representatives

May 1993

DEFENSE HEALTH CARE

Additional Improvements Needed in CHAMPUS's Mental Health Program



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Human Resources Division

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May 6, 1993

The Honorable Ike Skelton
Chairman, Subcommittee on Military Forces
and Personnel, Committee on Armed Services
House of Representatives

Dear Mr. Chairman:

Between fiscal years 1985 and 1989, the costs of mental health care under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) increased from \$272 million to \$613 million, even though the number of eligible beneficiaries remained constant at about 6 million.¹ In March 1991, the Department of Defense (DOD) submitted to the House and Senate Committees on Armed Services a report on its efforts to reduce these costs. And, in April 1991, DOD and we testified on issues concerning CHAMPUS mental health care.² This report provides an update on DOD's efforts to improve the management and quality of mental health care under CHAMPUS. Our scope and methodology are described in appendix I.

Background

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Inpatient care, the largest component of CHAMPUS mental health costs, increased from about \$200 million to almost \$500 million between fiscal years 1985 and 1989. Most of these costs are for mental health inpatient care for children and adolescents. In fiscal year 1989, CHAMPUS beneficiaries aged 19 and under accounted for 75 percent of the inpatient mental health days paid by CHAMPUS and more than 60 percent of all CHAMPUS mental health costs. A large portion—and the fastest growing component of the inpatient mental health care for children and adolescents—was provided in residential treatment centers (RTC).³ Between fiscal years 1985 and 1989, the cost of CHAMPUS-paid RTC benefits increased by about 240 percent—from \$38 million to about \$130 million.

Because of the Congress's concern about the rising costs of mental health care, the National Defense Authorization Act for Fiscal Year 1991 (P.L. 101-510) contained provisions that reduced some benefits and required

¹CHAMPUS pays for a substantial portion of the health care that civilian hospitals, physicians, and other providers give to Department of Defense beneficiaries. Retirees and their dependents, dependents of active-duty personnel, and dependents of deceased members obtain care from these providers when they cannot obtain it from military facilities.

²DOD's Management of Beneficiaries' Mental Health Care (GAO/HRD-91-18, Apr. 24, 1991).

³A psychiatric residential treatment center provides long-term treatment for children and adolescents with mental disorders who require a protected and structured environment, but for whom inpatient hospitalization or outpatient treatment is inappropriate.

preadmission authorization for mental health admissions. As discussed in our November 1991 report,⁴ however, CHAMPUS mental health benefits and cost-sharing requirements are still more liberal than those offered to private-sector and federal civilian employees. CHAMPUS benefits (1) have higher limits on the number of days of care covered than do standard insurance policies; (2) cover care in residential treatment centers, which is generally not a benefit in other plans; (3) provide for more outpatient visits; and (4) pay more types of professional providers. CHAMPUS also requires lower beneficiary cost-sharing than typical employer-sponsored health insurance: no premiums or lifetime dollar limits, a nominal fee for inpatient care for active-duty dependents, and a relatively low catastrophic limit.

Results in Brief

DOD has taken several actions to better manage CHAMPUS mental health costs and utilization and to improve the quality of care for beneficiaries. DOD has undertaken initiatives and demonstration projects that employ utilization management techniques similar to those used by private-sector companies and health plans that intensively manage mental health care. It has also instituted controls over payments to psychiatric facilities and improved standards for RTCs, which DOD systematically inspects with some follow-up to determine if problems are corrected. Because of these efforts, CHAMPUS mental health costs leveled off in fiscal years 1990 and 1991.

Several problems persist, however. For example, reviews of medical records have identified numerous instances of poor medical record documentation, potentially inappropriate admissions, excessive hospital stays, and poor-quality care. Also, inspections of RTCs continue to reveal significant health and safety problems, and corrective actions often take many months.

Moreover, DOD has proposed further changes to its methods of reimbursing psychiatric facilities. DOD should adopt these additional changes because it pays considerably higher rates for comparable services than do other public programs.

Mental Health Cost Control Efforts Are Working

CHAMPUS mental health costs increased by an average of more than 22 percent per year during fiscal years 1985 to 1989, but the increase slowed to slightly more than 3 percent in fiscal year 1990, and costs actually decreased slightly (less than 1 percent) in fiscal year 1991. In comparison,

⁴Defense Health Care: CHAMPUS Mental Health Benefits Greater Than Those Under Other Health Plans (GAO/HRD-92-20, Nov. 7, 1991).

CHAMPUS medical costs for services other than mental health rose about 16 percent in fiscal year 1990 and 12 percent in fiscal year 1991.

DOD has initiatives and demonstration projects under way to test cost-reduction techniques. (Appendix II describes these efforts.) The techniques include pre- and concurrent authorization of hospital admissions and stays, retrospective utilization review, establishment of provider networks, increased attention to beneficiary and provider education, and the offering of a broader continuum of mental health care, such as a partial hospitalization benefit. Additionally, DOD changed its method of reimbursing for inpatient psychiatric care and, wrote new standards and conducts regular inspections of RTCs. These techniques allow DOD to contain costs by shortening inpatient lengths of stay; obtaining discounts from providers; and directing patients to alternative, lower cost settings for care, such as outpatient treatment.

Despite DOD's success in controlling mental health costs, several areas need additional management attention, including (1) the high rate of potentially inappropriate hospital admissions and excessive lengths of stay identified by reviews of medical records, (2) health and safety problems identified during inspections of RTCs, and (3) high reimbursement rates DOD pays to psychiatric facilities.

Reviews of Medical Records Show High Rates of Potentially Inappropriate Hospital Admissions

For calendar year 1990, DOD's mental health utilization review contractor, Health Management Strategies International, Inc. (HMS), sampled 2 percent of the closed acute care mental health cases nationally each quarter⁵ and a statistically valid random sample of cases from 11 acute care facilities. HMS reviewed the medical records of each case to determine if the care was medically necessary; the number of inappropriate days of care, if any; and if the care provided was appropriate for the patients' condition.

Both the quarterly and facility reviews identified many instances of potentially inappropriate care:

- In about one-half of the cases, documentation in the medical record reviewed by a board-certified psychiatrist did not substantiate the medical necessity of the admission or the entire stay.
- In about one-half of the cases judged not medically necessary (or one-fourth of all cases), the medical record contained information that contradicted or was not provided during the telephone

⁵The number of cases reviewed as a result of this sampling ranged from 113 to 164 per quarter.

preauthorization/certification process. Had the information been available when the original certification was decided the certification may have been denied. For example, in some cases information regarding failed outpatient treatment was inaccurate, while in others, the acuity of the patient's symptoms was exaggerated.

HMS also identified several potential quality-of-care problems. For example, in some cases, although records described patients as suicidal, they did not indicate that any precautions were taken. In other cases, patients' safety may have been compromised because of questionable medication dosages or practices.

DOD officials concluded, however, that further study was needed because the findings indicated only that the medical records did not agree with the HMS records and that these disparities could be due to three factors:

- The medical records were incomplete or inaccurate.
- HMS made errors and should not have authorized the hospitalization.
- The providers gave false or misleading information to justify hospital admissions.

In January 1993, DOD instructed HMS to determine, for the facility reviews, which factors applied in each case where a disparity existed so that it could decide if any cases should be referred for criminal investigation. HMS reexamined the 157 cases (from 10 facilities) that its psychiatrists had determined to be medically unnecessary for some or all of the hospital stay. HMS determined that for 35 of the 157 cases there was clear evidence that a provider misrepresented information to HMS when the provider requested approval for a hospital admission or continued stay. In 67 cases, HMS determined that it made an error and should not have certified the admission or continued stay. In 55 other cases, HMS could not determine whether the provider or HMS was at fault.

We reviewed the cases and verified that (1) the criteria and procedures HMS used to certify admissions and continued stays were valid, (2) the admissions and stays that HMS questioned were medically unnecessary based on the medical record documentation, and (3) the reasons cited by HMS for these discrepancies were correct.

In response to these findings the Acting Assistant Secretary of Defense (Health Affairs) informed us in March 1993 that DOD has decided to take several actions. DOD will

- notify the facilities of the findings and inform them that all CHAMPUS admissions will be closely scrutinized for medical necessity and appropriateness of care for the next 12 months,
- refer to the Inspector General those cases where a provider misrepresented information to HMS, and
- notify each facility that there will be a retrospective denial of reimbursement for any 1992 care found to be medically unnecessary or inappropriate.⁶

DOD also plans to conduct additional facility reviews, focusing on providers identified during its quarterly reviews and providers who had more than 50 percent of their requests for admissions or continued stays denied by HMS. HMS will review open and recently closed cases from these providers and give them the opportunity to comment on the findings. DOD is considering additional options for dealing with problem providers, including inspecting acute care facilities and removing certain facilities as authorized CHAMPUS providers. Policies and procedures for dealing with these providers have not yet been developed, however.

Inspections of RTCs Continue to Reveal Problems

As part of a program to improve the quality of care provided in RTCs, DOD (using HMS) has systematically inspected all RTCs⁷ at least once and has drafted new standards that RTCs must meet to be CHAMPUS-certified providers. Before 1990, when the inspection program began, DOD inspections of facilities had been sporadic despite a history of quality-of-care and other problems with RTCs.

Inspections conducted since our April 1991 testimony have identified some of the same problems we described then: unlicensed and unqualified staff, inappropriate use of seclusion and medication, inadequate staff-to-patient ratios, and inadequate documentation of treatment.

Because of the inspections, many RTCs have improved their operations; DOD has terminated others from the program. Facility corrective action plans and HMS reinspection reports show, for example, that many facilities have replaced unqualified staff, instituted 24-hour nursing care, and more

⁶Until an October 18, 1991, DOD rule prohibited it, mental health care providers could seek payment from DOD beneficiaries for care provided even if the care was medically unnecessary and payment was denied by DOD.

⁷As of December 1992, CHAMPUS-certified RTCs numbered 56. Since the DOD inspection process began in 1990, 188 inspections have occurred. Sixty-three inspections were of facilities applying to become CHAMPUS-certified, and 125 inspections were for recertifications of facilities. Thirty-nine CHAMPUS-certified RTCs have been surveyed more than once.

selectively and appropriately use restraints and seclusion. In addition, 34 previously certified RTCs withdrew their request for certification before, during, or after the inspections. DOD has terminated 12 RTCs from the CHAMPUS program and notified several others of its intention to deny their recertification. Another 40 RTCs seeking first-time certification withdrew their applications after the inspections or were denied certification based on the inspections.

Except for immediate health and safety problems, resolving the problems found during surveys sometimes takes awhile. HMS prepares reports on survey findings and submits them to RTCs. The RTCs must prepare corrective action plans, addressing each finding. HMS reviews the RTC plans for corrective action and compares them with survey findings to determine their sufficiency. HMS resurveys some facilities found to have significant problems during inspections to verify that promised corrective action was taken. HMS also conducts verifications by telephone and written correspondence. This process often takes many months, averaging about 8 months from survey to the recertification or termination of a facility. In contrast, under the Medicare program, facilities found to have serious problems that make them noncompliant with participation conditions usually have 90 days to comply. Reinspections are made within this time frame.

In April 1991, DOD drafted procedures specifying, among other things, the criteria for survey frequency and for acting against providers that were not complying with DOD standards. DOD is awaiting a cost proposal from HMS for implementing the procedures and expects to have the procedures implemented by mid-1993.

CHAMPUS Pays Psychiatric Facilities More Than Other Government Programs Do

DOD has stated its intention to change CHAMPUS's mental health reimbursement methodologies to more closely reflect facility costs and inflationary increases and to provide beneficiary incentives to seek outpatient care. However, it has made little progress because it has concentrated on quality-of-care and other utilization review initiatives. Our work indicates that DOD pays psychiatric facilities considerably more than other government programs do for comparable services.

Although the current CHAMPUS system of per diem reimbursement has helped limit program cost increases for inpatient mental health, the per diem rates were based on providers' billed charges, not their costs. The rates were based on billing data from a period when providers' charges

were not subject to controls and had just increased significantly. Before fiscal year 1989 when no upper limit on rates existed, hospitals and RTCs essentially set their own CHAMPUS payment rates. Before the per diem calculations, hospital and RTC rates increased significantly. For example, average daily charges per CHAMPUS inpatient day rose by 17 percent from fiscal years 1987 to 1988. One RTC boosted its daily charges from an average of \$331 in fiscal year 1987 to \$531 in June 1988—a 60 percent increase.

CHAMPUS per diem rates are much higher than the daily operating costs of psychiatric hospitals and are also much higher than Medicare's reimbursement rates for the same psychiatric hospitals. We compared the fiscal year 1990 CHAMPUS per diem rates for 21 high-volume CHAMPUS psychiatric hospitals to the costs in each facility's Medicare cost report. The hospitals made large profits, on average, on CHAMPUS patients. Subtracting their average daily costs from their CHAMPUS per diem rates revealed an average daily profit on CHAMPUS patients of about \$99, or about 22 percent above the average cost per inpatient day. In contrast, the average profit margin per day for other patients and payers was about \$66 or 14 percent above the average daily costs.

We also compared the fiscal year 1990 CHAMPUS per diem rates for these high-volume psychiatric hospitals to the average daily Medicare payments and Medicare-allowed costs for those hospitals. For these hospitals, the CHAMPUS per diem rates were significantly higher than the average daily Medicare payment. On average, the hospitals were paid 39 percent more per day for CHAMPUS patients than for Medicare patients. For these hospitals in aggregate, CHAMPUS paid an average of \$170 per day more than the Medicare-allowed daily costs, and this was more than 15 times larger than the average Medicare-allowed profit.⁸

We also compared the state-authorized daily rates of seven RTCs in Florida and Virginia to the CHAMPUS per diem rates for those RTCs.⁹ For six of the seven RTCs, the CHAMPUS rates were significantly higher than the state rates. One RTC had a CHAMPUS rate that was \$167 higher or 80 percent more than

⁸Medicare allowed proprietary psychiatric hospitals to claim a profit equal to the rate of interest earned by the Medicare trust fund times the equity in the facility. Equity is defined as owner involvement plus working capital.

⁹We selected Florida and Virginia because DOD expenditures for RTC care in these states were high compared to other states. The RTCs we selected had state rates that were all inclusive, like CHAMPUS, meaning that the rates cover all services, including professional fees and room and board. These RTCs provide the same level and intensity of services under the CHAMPUS and state rates.

its state rate in fiscal year 1991. The average daily CHAMPUS rate for all seven RTCs was \$83 higher or 36 percent more than the average state rate.

By comparing cost data reported by Texas to CHAMPUS per diem rates, we calculated the profit margins on CHAMPUS-paid patient days for three Texas RTCs. (Texas had the highest total CHAMPUS RTC costs of any state.) The CHAMPUS profits for one of the RTCs exceeded its average cost per day by 65 percent, resulting in a profit of about \$111 per day. The average daily profit for all three Texas RTCs in aggregate was \$53—an average profit margin of 27 percent.

Another problem that DOD needs to address is its method of paying specialized treatment facilities. This category of facilities consists mostly of drug and alcohol treatment facilities, approximately 250 of which are being paid under CHAMPUS. In fiscal year 1991, these facilities were paid more than \$8 million. When DOD converted to the per diem method of paying psychiatric facilities several years ago, it did not include specialized treatment facilities in its payment reform. Instead, it continues to pay these facilities on the basis of their billed charges. These facilities set their own fees and can increase them freely—without controls over their charges. Some of these facilities are paid more on a daily basis than are psychiatric hospitals.

DOD also stated its intention to change the index factor used to annually update CHAMPUS RTC per diem rates from the consumer price index for urban medical services (CPI-U) to the considerably lower hospital market basket index factor that CHAMPUS and Medicare use under their prospective payment systems. The CPI-U increased by 62 percent in the 8 years between 1983 and 1990. In contrast, the Health Care Financing Administration's market basket factor, used by Medicare and CHAMPUS to update rate ceilings for hospitals, increased by less than 25 percent during the same period. The market basket factor would be more appropriate than the CPI-U because it reflects increases in the amounts hospitals pay for goods and services. The CPI-U reflects increases in charges by health practitioners and facilities.

In mid-1992 DOD contracted with a consulting firm to assist it in analyzing alternative reimbursement methodologies for mental health care. The contractor's initial report is to be delivered by the end of March 1993.

Finally, DOD has not corrected the bias toward patients' receiving inpatient rather than outpatient care under CHAMPUS that results from inpatient care

being less expensive to some beneficiaries than outpatient services. Currently, dependents of active-duty members pay \$9.30 per day or \$25, whichever is greater, for CHAMPUS inpatient care. For outpatient care, dependents, after satisfying a \$150 deductible, pay 20 percent of the charges. This incentive for institutionalization also applies to all medical conditions, not just mental health. We continue to believe, as we stated in our April 1991 testimony, that the benefit package needs modification to overcome the financial bias toward providing CHAMPUS inpatient care to beneficiaries.

Conclusions

DOD has taken many positive steps to better control CHAMPUS mental health costs and improve the quality of care provided to its beneficiaries. These efforts have begun and should continue to produce positive results. Additional opportunities and actions exist, however, that we believe DOD should take to further constrain costs and improve quality.

First, DOD should increase efforts to obtain needed corrective actions by RTCs in noncompliance with DOD standards so that these problems cease. Standards, which include termination for noncompliance, should be specified, and termination proceedings, time frames, and reinspection provisions similar to those used by Medicare for mental health facilities should be adopted.

Second, because DOD reimburses psychiatric hospitals and RTCs at higher rates than do other government payers, it should modify its payment system and annual adjustments for inflation to more closely resemble other programs such as Medicare, adjusting where necessary for differences such as patient age and case mix. Reimbursement rates for specialized treatment facilities that continue to be paid billed charges also should be adjusted to parallel other CHAMPUS reimbursement reforms.

Third, the financial incentives for beneficiaries to seek CHAMPUS inpatient care should be changed to optimize the use of effective outpatient treatment. This should be accomplished by raising the amount that dependents of active-duty members pay for inpatient care. This amount should be high enough to reverse the present incentive to use inpatient care.

Recommendations

We recommend that the Secretary of Defense take the following additional steps to control costs and improve the quality of mental health care:

- Implement specific definitions, procedures, and time frames to govern the decertification or other actions DOD should take against RTCs found to be noncompliant with DOD standards.
- Establish a system of reimbursing psychiatric facilities, RTCs, and specialized treatment facilities based on a cost-based system similar to Medicare, adjusted appropriately for differences in beneficiary demographics rather than the present per diem or billed charges system.
- Adopt the hospital annual index used in the Medicare and CHAMPUS prospective payment systems to adjust the annual reimbursement to RTCs.
- Reverse the financial incentives to use inpatient care by introducing larger copayments for CHAMPUS inpatient care.

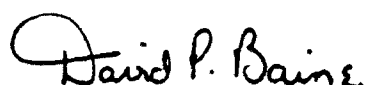
Agency Comments

We obtained written comments on a draft of this report from DOD (app. III). In general DOD agreed with the report's findings. DOD believes it has made significant strides during the past 3 years toward improved management of CHAMPUS mental health benefits.

DOD generally agreed with the report's recommendations. However, it said that it is not certain that a cost-based system similar to Medicare is the most appropriate model for CHAMPUS. Also, DOD said the problem of financial incentives to seek inpatient mental health care is minimized because all nonemergent care must be preauthorized. On both issues, DOD said it will explore alternatives to the present system.

We are sending copies of this report to appropriate congressional committees; the Secretary of Defense; the Director, Office of Management and Budget; and other interested parties. If you have any questions, please call me at (202) 512-7101. Other major contributors to this report are listed in appendix IV.

Sincerely yours,



David P. Baine
Director, Federal Health Care
Delivery Issues

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Abbreviations

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CPI-U	consumer price index for urban medical services
DOD	Department of Defense
HMS	Health Management Strategies International, Inc.
RTC	residential treatment center

Scope and Methodology

We conducted fieldwork at the Office of the Assistant Secretary of Defense (Health Affairs), Washington, D.C.; CHAMPUS Headquarters, Aurora, Colorado; Health Management Strategies International, Inc., Alexandria, Virginia; Health Care Financing Administration, Region VIII, Denver, Colorado; CHAMPUS Reform Initiative, Rancho Cordova, California; Contracted Provider Arrangement, Norfolk, Virginia; and a catchment area management demonstration project at Evans Army Hospital, Fort Carson, Colorado.

In studying DOD's efforts to improve the management of CHAMPUS mental health benefits, we

- reviewed regulations, policies, procedures, contracts, reports, and proposals pertinent to the CHAMPUS mental health program;
- obtained and reviewed professional studies, surveys, and journal articles on private-sector management techniques to control the utilization, costs, and quality of mental health care;
- interviewed officials and staff of the Office of the Assistant Secretary of Defense (Health Affairs) and CHAMPUS;
- reviewed utilization management and quality activities performed under contract by Health Management Strategies International, Inc.;
- conducted site visits, interviewed DOD project managers and contractor personnel, and obtained documentation on DOD and CHAMPUS initiatives and demonstration projects;
- analyzed trends in the utilization and costs of CHAMPUS mental health benefits, concentrating on key statistical indicators of program activity between fiscal years 1985 and 1990;
- documented the history of rate-setting issues for CHAMPUS psychiatric hospitals and RTCs;
- obtained RTC rate and cost data from several states and compared state-authorized rates (and the underlying costs) with the rates charged to CHAMPUS;
- interviewed officials at and obtained documentation from the Region VIII office of the Health Care Financing Administration, Department of Health and Human Services, on the method used by Medicare to reimburse psychiatric hospitals and on selected hospitals' costs; and
- compared CHAMPUS per diem rates for a number of high-volume psychiatric hospitals to these hospitals' costs and Medicare-allowed rates as contained in the Health Care Financing Administration's Hospital Support Data System. Initially, we selected the top 30 CHAMPUS high-volume hospitals for this comparison. The Medicare database contained sufficient data, however, to make comparisons for only 22 hospitals' costs and 21

hospitals' Medicare-allowed rates. Medicare had no data on five hospitals, and data inaccuracies or missing data prevented us from making comparisons involving others.

We conducted our review between September 1991 and March 1993 in accordance with generally accepted government auditing standards.

CHAMPUS Initiatives and Demonstration Projects

CHAMPUS has attempted to curtail increases in mental health costs while maintaining beneficiaries' access to quality care. The National Mental Health Utilization Management Program, the Contracted Provider Arrangement, the CHAMPUS Reform Initiative, and Catchment Area Management Projects—all CHAMPUS initiatives and demonstration projects—employ techniques used by private-sector companies and health plans that intensively manage mental health benefits. These techniques include managing utilization, establishing provider networks through which discounts are negotiated, offering a broad continuum of care, implementing quality assurance functions, and emphasizing provider and beneficiary education and relations.

National Mental Health Utilization Management Program

Under a contract with DOD beginning in January 1990, Health Management Strategies International, Inc. (HMS) performs nationwide utilization review services, including precertification, concurrent reviews, and retrospective reviews.¹ HMS also assists CHAMPUS in quality assurance functions, such as certifying or decertifying RTCs, through review of paperwork and on-site inspections of facilities. In addition, HMS provides a beneficiary and provider relations and education program and operates a management information system that supports analysis of its contract activities. The contract holds HMS at risk for its operational costs but not for the cost of CHAMPUS claims.

Utilization Management

HMS conducts utilization review, the primary activity under the contract, by telephone and by review of documentation submitted by providers. Criteria that HMS developed are used in the review process. Preadmission approval, when adequately justified, is granted for a specified time period. Upon completion of this time period, continued-stay reviews are conducted if hospitalization for acute care beyond the initial authorization is requested.

HMS also reviews requests for waivers for extended stays beyond the CHAMPUS-authorized day limits. Waivers for acute care, if given, can be for up to 7 days, after which they must be reapproved at intervals of up to 7 days. Outpatient care that exceeds 23 visits per calendar year or 2 visits a week also requires HMS approval.

¹HMS does not perform these services for the CHAMPUS Reform Initiative in California and Hawaii or the Contractor Provider Arrangement demonstration project in Virginia.

HMS data show positive results from its utilization review efforts. For example, between 1990 and 1991, average lengths of stay for psychiatric treatment programs were reduced by 5 days or 21.2 percent. Also, approximately 8 percent of requested admissions and 14 percent of requests for continued stays in 1991 were deemed medically unnecessary and denied.

Quality Assurance

HMS inspects RTCs and reviews paperwork to assist DOD in certifying or decertifying RTCs. HMS also has a program to validate, on a retrospective basis, the medical necessity, appropriateness, and quality of the mental health care provided at specific facilities.

Provider and Beneficiary Relations

A provider advisory council, program manual, newsletters, and meetings serve to educate providers. A beneficiary advisory council and brochure and news articles educate beneficiaries.

Contracted Provider Arrangement

The Contracted Provider Arrangement is a managed mental health care demonstration project covering CHAMPUS beneficiaries in Virginia's Tidewater area. DOD selected this area because its CHAMPUS per capita mental health costs were twice the national average before 1987. DOD intended the project to test the practicality of awarding a fixed-price contract, with the contractor at risk for providing all necessary mental health and substance abuse care and claims processing. The project offers a broad continuum of care and employs such management techniques as utilization management, provider networks and discounts, quality assurance, and provider and beneficiary relations. The first contract extended from October 1986 to March 1989. In a contract recompetition, a new contractor—First Hospital Corporation—won a 5-year contract, with services beginning April 1, 1989, for \$143 million.

The project has saved money as indicated by two separate measures: (1) current project costs compared to preproject costs and (2) estimated current costs for the area had the project not been implemented. Since 1988, annual project costs have averaged \$32 million compared to \$37 million in 1986 before the project began. Estimates of what costs would have been if mental health costs in Virginia increased at the CHAMPUS national average show the project has saved about \$148 million. The project saved money primarily from changes in utilization patterns (more outpatient care and less inpatient care) and reductions in provider

reimbursement rates. On the other hand, some beneficiaries and the media have criticized the project for unduly restricting access to care. (A recent CAO report provides additional details on savings, utilization, access, quality, and management issues concerning this project.)²

Utilization Management

Utilization management under the demonstration project concentrates on inpatient care, which is closely managed. Mental health workers at eight intake centers perform initial face-to-face assessments of beneficiaries seeking care, preauthorize care, and make referrals. If mental health workers consider inpatient care appropriate, they authorize it for 3 days. If outpatient care is needed, 2 visits are authorized. Concurrent review and case management of acute inpatient care is performed by case managers, who review the cases on site within 48 hours of inpatient admissions.

Outpatient care is not managed as intensively as inpatient care. Intake centers may approve extensions of 2 visits for up to 24. Additional outpatient visits require contractor approval of a treatment report prepared by the provider.

Provider Networks and Discounts

The contract project manager, First Hospital Corporation, has contracted with a network of institutional and individual providers for reduced rates. As of April 1992, the network consisted of five psychiatric hospitals, one RTC, and more than 500 individual mental health practitioners. The individual practitioners represented about 64 percent of those in the Tidewater area. By belonging to the network, the providers agree to participate in the project's case management and quality review programs. Regardless of whether providers participate in the network, however, they are paid the same amount. Providers join the network to get patient referrals from the contractor.

Individual providers are reimbursed under a fee schedule, and institutional providers are paid under a per diem system. The fee schedules are structured to reimburse outpatient services more favorably than inpatient professional services. The per diem system involves a three-tiered rate structure under which the reimbursement amount decreases as the length of stay increases.

²Defense Health Care: CHAMPUS Mental Health Demonstration Project In Virginia (GAO/HRD-93-53, Dec. 30, 1992).

Quality Assurance

The demonstration project has both internal and external quality assurance functions. The internal program has a full-time staff, a written plan, quality assurance criteria, and an oversight committee. The program stresses review of inpatient cases; about 50 percent of inpatient acute and partial hospitalization cases are randomly selected for review. Cases can undergo three layers of review: all are first reviewed by nurses; potential quality-of-care problem cases are then reviewed by the director of quality assurance. When deemed necessary, cases are submitted to peer review committees of providers who practice in the community.

Since the start of the demonstration project, DOD has contracted with SysMetric to provide an independent external quality assurance review of inpatient care. As with the internal quality review function, the external function employs multiple layers of review. Cases are reviewed concurrently and retrospectively, and reports on findings are submitted to CHAMPUS monthly, quarterly, and annually.

Provider and Beneficiary Relations

First Hospital's program for provider relations includes developing handbooks on CHAMPUS directives and requirements for coordinating care, mailing newsletters, and conducting workshops. In addition, a provider advisory board, consisting of network and non-network providers, was established to open and maintain communications. Providers are also surveyed periodically about their satisfaction with the project.

The contractor also has a prevention and education program for beneficiaries. This program includes brochures, educational workshops, coordination with community and military support organizations, and listings of community providers. Finally, the contractor has a department that responds to inquiries from beneficiaries and providers on claims and other matters.

CHAMPUS Reform Initiative

The CHAMPUS Reform Initiative is a managed-care demonstration project covering California and Hawaii. Under a 5-year, fixed-price contract, Foundation Health Corporation and its subcontractors provide all medical services and claims processing for CHAMPUS beneficiaries in the two states. In managing the mental health benefit, the initiative employs the same techniques generally used in the private sector. These include utilization management, establishment of provider networks with which discounts have been negotiated, increased attention to quality assurance, and an emphasis on provider and beneficiary relations. In addition, the project

augments the capabilities of military treatment facilities by placing project staff or other resources in these facilities to treat beneficiaries.

Utilization Management

Under the initiative, mental health care specialists or psychiatric nurses (referred to as health care finders) located at military hospitals and selected other locations make initial assessments and referrals to appropriate providers. When beneficiaries use network providers for inpatient care, utilization management nurses are notified upon admission, and cases are reviewed on site within 72 hours of the admission. Following the initial review, concurrent reviews take place at 7-day intervals. For outpatient care, treatment plans and summaries submitted by providers are reviewed following the sixth visit and at 10-visit intervals thereafter.

Care provided to beneficiaries using non-network providers is reviewed retrospectively at less frequent intervals. Written criteria, based on CHAMPUS policy and developed by the contractor, are used for all utilization reviews.

An additional feature of the initiative involves augmenting the capability of military treatment facilities by placing contractor personnel and other resources in these facilities. By augmenting capability when there is excess capacity (such as unused wards), the project reports lower overall costs. As of April 1991, the initiative reported that 20 mental health resource-sharing agreements were in effect and that it had saved \$3 million. For example, as a result of resource sharing, the San Diego Naval Hospital was able to open an adult inpatient psychiatric ward, reducing by half the number of inpatient psychiatric referrals to CHAMPUS in the San Diego area.

Provider Networks and Discounts

The initiative's contractor, Foundation Health Corporation, has subcontracted with a large network of individual and institutional providers. As of March 1991, nearly 1,300 professional mental health providers belonged to the network. According to Foundation, this network provides more than half of the care delivered under the initiative. Additionally, Foundation has negotiated discounts with many of the network institutions, ERCS, and professional providers. For example, for the most common mental health outpatient procedure, individual psychotherapy, negotiated discounts range from 20 to 26 percent for psychiatrists and from 30 to 40 percent for psychologists.

Quality Assurance

Quality assurance under the initiative project consists of two processes: checking providers' credentials (for example, education and licenses) and using potential quality indicators to review cases. In the case review process, cases are matched against potential quality indicators, such as a set of standard practices and clinical outcomes. When the match identifies treatment that may deviate from community standards, project officials discuss the treatment with the provider or refer the case to CHAMPUS for corrective action.

Provider and Beneficiary Relations

Under the initiative, considerable attention goes to establishing effective relations with providers and beneficiaries. For example, project staff meet with providers, conduct community training sessions and workshops, visit provider offices, and give speeches at meetings of provider organizations. Further, Foundation's management seeks input from advisory committees of representatives of professional provider organizations. And, finally, periodic bulletins and other written materials are sent to all providers.

The health care finders attend primarily to beneficiary relations. Knowledgeable about providers and other community resources, the finders not only make referrals but also sometimes make appointments for beneficiaries. Beneficiary surveys have reported a high level of satisfaction with providers resulting from improved access and reduced cost-shares and paperwork.

Catchment Area Management Projects

Three catchment area management projects are currently under way: one by the Navy and two by the Air Force. Two such Army projects ended in 1992.³ All five of the projects employ utilization management techniques and provider networks and discounts. Additionally, all of the projects stress maximizing the use of military treatment facilities before sending patients to CHAMPUS.

Utilization Management

All of the catchment area demonstration projects use HMS to perform precertification and concurrent reviews of inpatient care and periodic reviews of outpatient visits. The only exception was the Army's Fort Carson project, for which project staff conducted utilization review of enrollees (HMS reviews nonenrollees). HMS applied the same utilization

³The projects are Naval Hospital, Charleston, South Carolina; Bergstrom Air Force Base, Texas; and Luke-Williams Air Force Base, Arizona. The Army projects were Fort Sill, Oklahoma; and Fort Carson, Colorado.

review criteria to beneficiaries in the demonstration projects as it did to beneficiaries in other parts of the country for which it is responsible.

Additionally, to lower costs, the projects have augmented their military treatment facilities' outpatient psychiatric capabilities through use of the Partnership Program. This program allows civilian providers to practice in military facilities as long as they agree to accept reduced fees. In addition, Fort Carson opened a new 12-bed psychiatric ward, and Charleston plans to hire civilian government and contract personnel to augment its inpatient psychiatric capabilities. The other demonstration sites did not have the excess capacity needed to provide inpatient psychiatric services.

Provider Networks and Discounts

All demonstration projects have negotiated discounts with providers in the form of per diem amounts and percentage reductions (for example 20 percent) from CHAMPUS allowable amounts. Some projects have negotiated with individual hospitals and professional providers; others have negotiated with preferred provider organizations. When services are unavailable at the military treatment facility, health care finders attempt to steer patients to network providers that have agreed to the discounted fees.

Quality Assurance

Quality assurance functions for civilian providers are limited under the demonstration projects. One project established an outpatient program in which a nurse reviewed a sampling of cases. And several projects reviewed providers' credentials before accepting them into the provider network.

Provider and Beneficiary Relations

To solicit participant concerns and encourage interest in participation, all of the catchment area demonstration projects emphasize provider and beneficiary relations, as well as education through informational brochures, newsletters, and meetings.

Other Initiatives

DOD is undertaking several other mental health reforms and improvements. Among them are (1) awarding a national quality monitoring contract, (2) developing criteria and standards for measuring the quality of mental health care, (3) developing standards and inspecting specialized treatment facilities, and (4) adopting a partial hospitalization benefit nationwide. These efforts are at various stages of development.

Comments From the Acting Assistant Secretary of Defense



HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

MAR 05 1993

Mr. David P. Baine
Director, Federal Health Care Delivery Issues
Human Resources Division
United States General Accounting Office
Washington, DC 20548

Dear Mr. Baine:

This is the Department of Defense (DoD) response to the General Accounting Office GAO draft report, "DEFENSE HEALTH CARE: Additional Improvements Needed in CHAMPUS' Mental Health Program," dated January 14, 1993 (GAO Code 101390), OSD Case 9306. The Department agrees with the report findings and the description of the demonstration projects. The Department also concurs or partially concurs with the recommendations.

As recognized by the GAO, the Department has made significant strides during the past three years toward improved management of Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) mental health benefits. The accomplishments achieved thus far are likely unprecedented among third party payers. The Department is continuing its efforts to further improve cost control and to improve the overall quality of mental health care.

With regard to the problems identified during the facility survey process, in a substantial number of cases, the Department has proposed and effected terminations of residential treatment centers from their status as authorized CHAMPUS providers. While the termination process occasionally takes an extended period of time, oftentimes it is the result of affording facilities due process. Relative to protocols for dealing with non-compliant facilities, there are certain procedures already in place. Chapter nine of the CHAMPUS regulation (DoD 6010.8-R), for example, addresses administrative remedies in situations requiring action to enforce provisions of law, regulation, and policy in the administration of the CHAMPUS to ensure quality care for its beneficiaries.

The DoD comments on the report recommendations are provided in the enclosure. The DoD appreciates the opportunity to comment on the draft report.

Sincerely,

Edward D. Martin

Edward D. Martin, M.D.
Acting Assistant Secretary of Defense

Enclosure

**Appendix III
Comments From the Acting Assistant
Secretary of Defense**

GAO DRAFT REPORT--DATED JANUARY 14, 1992
(GAO CODE 101390) OSD CASE 9306

**"DEFENSE HEALTH CARE: ADDITIONAL IMPROVEMENTS NEEDED
TO CHAMPUS' MENTAL HEALTH PROGRAM"**

DEPARTMENT OF DEFENSE COMMENTS

RECOMMENDATIONS

- o **RECOMMENDATION 1:** The GAO recommended that the Secretary of Defense take additional steps to control costs and improve the quality of mental health care by implementing specific definitions, procedures, and timeframes to govern the decertification or other actions the DoD should take against residential treatment centers that are found to be out of compliance with DoD standards. (p. 17/GAO Draft Report)

DoD RESPONSE: Additional administrative definitions and protocols regarding the residential treatment center certification and decertification process were developed and forwarded to the national mental health utilization management contractor on January 28, 1993 requesting a technical and cost proposal for implementation. The contractor's proposal is expected by March 2, 1993.

- o **RECOMMENDATION 2:** The GAO recommended that the Secretary of Defense take additional steps to control costs and improve the quality of mental health care by establishing a system of reimbursing psychiatric facilities, residential treatment centers, and specialized treatment facilities, based on a cost-based system similar to Medicare--adjusted appropriately for differences in beneficiary demographics, rather than the present per diem or billed charges system. (p. 17/GAO Draft Report)
- o **DoD RESPONSE:** The DoD agrees that additional attention to possible changes in the CHAMPUS mental health reimbursement methodologies is required; however, without a thorough analysis of the alternatives, the Department is not certain that a cost-based system, similar to that employed by Medicare, is the most appropriate model for the CHAMPUS. An evaluation of the CHAMPUS reimbursement for psychiatric care is currently underway in the DoD, under the direction of the

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Deputy Assistant Secretary of Defense (Health Services Financing). A contract with a consulting firm also has been established to assist in the analysis of potential options, and their initial report will be delivered by the end of March 1993.

- o **RECOMMENDATION 3:** The GAO recommended that the Secretary of Defense take additional steps to control costs and improve the quality of mental health care by adopting the hospital annual index used in the Medicare and the CHAMPUS prospective payment systems to adjust the annual reimbursement to the residential treatment centers. (p. 17/GAO Draft Report)

DoD RESPONSE: The index used to annually adjust CHAMPUS reimbursement rates will be addressed in conjunction with changes that result from the study of mental health reimbursement methodologies, discussed in the DoD response to Recommendation 2. Again, that effort falls under the purview of the Deputy Assistant Secretary of Defense (Health Services Financing).

- o **RECOMMENDATION 4:** The GAO recommended that the Secretary of Defense take additional steps to control costs and improve the quality of mental health care by reversing the financial incentives to use inpatient care by introducing larger copayments for CHAMPUS inpatient care. (p. 17/GAO Draft Report)

DoD RESPONSE: Partially concur. The Department recognizes that for dependents of active duty military, there is a financial incentive to seek inpatient health care of all types because they incur a lower out-of-pocket expense. In the case of mental health care provided to those beneficiaries under the CHAMPUS, the problem is substantially minimized, because all non-emergent inpatient care must be preauthorized. Such authorization is granted only if the care is medically necessary at that level, regardless of the financial interests of the patient. Therefore, the DoD will not immediately pursue changing the CHAMPUS cost sharing arrangements for active duty dependents relative to only mental health care. Rather, the Department will continue to explore ~~with the new Administration~~ the possibility of doing so in the context of all health care.

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